

diagnosis. Disagreements between primary and secondary care assessments were reviewed by a multidisciplinary team. Those of clinical importance were included in the analysis. *Results:* 29 of 44 practices wanted to take part. In the six selected practices 312 tests were completed. Mean age was 64 years (19-94 yrs), 52% female, mean predicted FEV1 69% (16-127%). 77 of 185 tests reported as acceptable in primary care were judged unacceptable by the specialist. 136 tests were judged obstructive by the specialist of which 85 were identified as obstructive by the primary care teams. In 129 of 218 (59%) tests there was complete agreement about level of severity. Practices differed in the frequency of disagreement with the specialists but in all there were disagreements in more than 15% of tests. *Conclusion:* On-line reporting of primary care spirometry is feasible and primary care teams are interested in it. The level of disagreement between primary care and specialist interpretation of the tests suggests that specialist reporting of tests is essential in these practices if primary care spirometry is to be carried out to an acceptable standard.

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ABS49: Splitting COPD and asthma: Validation of the differential diagnosis questionnaire (DDQ) in Australian primary care

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Introduction: Diagnostic confusion between COPD and asthma abounds in clinical practice and epidemiological surveys, as symptoms are non-specific. Spirometry is essential for the diagnosis of COPD, but is neither widely used nor reliably performed in general practice. The DDQ was developed to help GPs differentiate patients with respiratory symptoms into the category 'likely COPD'. *Aims and objectives:* To validate the DDQ prospectively in Australian primary care. *Subjects and Methods:* Forty-two GPs in Adelaide, Brisbane and Sydney recruited patients aged >40 years with a previous diagnosis of asthma or COPD, or with recent respiratory medication prescription. Diagnostic validity - DDQ scores were compared to spirometry in 131 patients, using two pre-determined cutpoint scores: 24.5 = 'high likelihood' (HL) and 18.5 = 'low likelihood' (LL). Test-retest reliability was tested in 73 of these patients. *Results:* Subject characteristics - 79% smoked >10 pack-years; M:F=56:44; 57% were aged >60; previous diagnoses were asthma (64%), COPD (44%) or both (13%). Utility of DDQ - HL Cutpoint: Sensitivity=63%, Specificity=76%, Positive Predictive Value=67%. LL Cutpoint: Sensitivity=82%, Specificity=44%, Positive Predictive Value=77%. Area under the Receiver Operating Curve=0.72 (moderate diagnostic agreement between DDQ and spirometry). Reliability was good ($\kappa=0.78$). These characteristics are similar to those previously obtained from UK/US, though some symptoms in Australia appear less helpful in contributing to the differential diagnosis model. *Conclusions:* The DDQ is a valid and reliable tool for helping GPs in Australia differentiate patients with a high likelihood of COPD from those unlikely to have COPD. Further work may help to develop greater discriminative value for the DDQ in Australia, enabling the GP to prioritise patients more effectively for spirometry confirmation.

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ABS50: Study of resources in asthma and COPD in the community of Madrid (Spain)

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Introduction: Respiratory medicine is developing in primary care. We describe the resources available. In a second phase, we will study health results. *Aims and objectives:* To learn about resources (infrastructure and process) related with Asthma and COPD in the public centers of the Community of Madrid (Spain). *Subjects and methodology:* A descriptive, cross-sectional study. A postal survey addressed (2 mailings) to the leaders of all the health centers (227), between November (2000) and April (2001). Response: 156 (68.7%). A previous study over 44 coordinators (nominal group), added 10 items and changed 4. Variables of infrastructure: existence and/or revision of cardiopulmonary resuscitation equipment (CPRE), spirometry, pulse oximeter, peak flow, inhalation devices and educational tools. Variables of process: existence of protocol, quality control, health education, provision of systems, continued education, waiting list. *Results:* Spirometry was available in 102 centers (65.4%), calibrated habitually in 60 (38.5%), there was CPRE in 142 (91%), pulse oximeter in 19 (12.2%). peak flow in 53.8%, 27.6% and 43.6% of the medical consultations, infirmary and emergency departments. There was an asthma protocol in 53 centers (34%) and COPD in 131 (84%). There was quality control in asthma in 10 centers (6.4%) and COPD in 52 (38.3%). There was grouped education in asthma in 22.4% and 19.2% in COPD. 60.3% of asthmatics and 93.7% of COPD patients were referred to pneumology. 7.1% of the asthmatic patients waited less than 31 days to be attended in allergy, as opposed to 49.9% in pneumology. *Conclusions:* Some deficiencies in infrastructure and process were detected with evidence of less development in the attention to the asthmatic patient. Also, there was little activity in respect of health education.

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ABS51: Can you be a generalist and a specialist? Stakeholders' views on a respiratory General Practitioner with a Special Interest service

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Introduction: General Practitioners with Special Interests (GPwSIs) have a potentially important role in delivery care for people with long-term respiratory diseases. The development of a GPwSI service within a Primary Care Trust (PCT) involves a process of 'transitional change' which impacts on all stakeholders, who may embrace or resist change. *Aims and objectives:* The objective of the current study is to explore the attitudes and views of stakeholders to the provision of a respiratory GPwSI service within the six PCTs in Leicester, UK. *Subjects and methods:* Using a qualitative design, GPs, nurses, secondary care doctors, nurse specialists, physiotherapists, a healthcare manager and patients with respiratory disease took part in focus groups and interviews. *Results:* The 25 participants expressed diverse opinions about the challenge of integrating specialist services with generalist care and the specific contribution that GPs might make to the care of people

with chronic respiratory disease. A range of potential roles for a respiratory GPwSI, working as part of a multi-disciplinary team, were suggested, and a number of practical issues were highlighted. For the role to succeed, the GPwSI needs to have the trust of their primary and secondary care colleagues as well as the patients, to be a credible practitioner, and to be politically astute potentially enabling them to act as a champion supporting the transition process within the local health service. **Conclusions:** The introduction of a respiratory GPwSI service represents a challenge to traditional roles which, whilst broadly acceptable, raised a number of important issues for the stakeholders in our study. These perspectives need to be taken into account if workforce change is to be implemented successfully.

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ABS52: Organisation of asthma and COPD care in primary health care in Mid-Sweden

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Objective: To investigate the organisation of primary health care with regard to management of asthma and COPD and relate it to the guidelines and quality indicators for organisation stated by the Swedish National Board of Health and Welfare and to an earlier study in the area. **Background:** The Swedish National Board of Health and Welfare assessed quality indicators for the organisation and equipment for asthma and COPD in primary health care in 2004. These are spirometer, pulse oximeter for assessing respiratory impairment, nebuliser for emergency treatment and an asthma/COPD clinic for patient education. **Method:** A postal survey in 2005 to 56 randomly selected primary health care centres in Mid-Sweden. The survey included questions about access to an asthma/COPD clinic, spirometer, pulse oximeter, nebuliser, organisation for smoking cessation and rehabilitation. **Results:** All centres answered the survey. 93% had a spirometer, 83% pulse oximeter, 90% nebuliser and 64% asthma/COPD clinic. 65% had access to a program for smoking cessation within primary care. Regarding resources for COPD patients 63% centres had access to physiotherapy, 71% to occupational therapy, 41% to a dietician and 93% to a social welfare official or psychologist. **Conclusion:** The possibilities to offer patients with asthma and COPD sufficient care is good regarding access to diagnostic tools as spirometers and pulse oximeters and nebulisers, while access to education through an asthma/COPD clinic is insufficient. Compared to the results from the AIM-study in 2000 primary health care centres with asthma clinics have increased from 52% to 64% and access to spirometer from 76% to 93%. Only two-thirds of the centres can offer a program for smoking cessation which is insufficient. The study shows that many centres have the resources to start pulmonary rehabilitation for patients with COPD.

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ABS53: Does the clinical COPD questionnaire (CCQ) score reflect reality in individual patients?

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Introduction: Patient Reported Outcome (PRO) measures are important in assessing effectiveness in clinical trials. The use of PROs could also provide valuable information for health care professionals in routine clinical practice. The Clinical COPD Questionnaire (CCQ) is a validated 10-item PRO assessing the health status of COPD patients (Health Qual Life Outcomes. 2003 Apr 28;1(1):13). **Aims and objectives:** To assess the validity of the CCQ on individual level. **Subjects and methods:** COPD patients visiting two out-patient clinics completed the CCQ before consulting their pulmonologist. These CCQ scores were compared with (i) the CCQ score completed about the patient by the blinded pulmonologist directly after the consultation in the first half of the patients and (ii) data from a semi-structured interview with the patient. The interviews were transcribed, analyzed and converted to CCQ scores by the researcher. Differences in CCQ scores between patient and (i) doctor and (ii) interview were analyzed. The number of differences exceeding the Minimal Clinically Important Differences (MCID) of the CCQ (0.4) were counted. **Results:** 44 patients (mean age 66 (±7) yr; 72% male; FEV1% predicted 44 (±14); mean total CCQ score 2.2 (±0.9)) were included. The correlation between the doctor vs patient CCQ score (method i) was $r = 0.87$, $n = 22$. The correlation between the interview and the patient (method ii) CCQ score was $r = 0.93$, $n = 44$. The number (%) of times the difference in total CCQ score exceeded the MCID was 8 (36) and 4 (9) respectively between patient and doctor and patient and interview. The interviews suggest that differences in scores between interview based CCQ score and patient CCQ score can be explained by patients' cognitive level and multiple co-morbidity. **Conclusion:** The CCQ can be trusted in routine clinical practice to assess COPD related health status, because of the high agreement between measurements, and the low number of differences exceeding the MCID between CCQ scores based on the interview and completed by the patient.

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ABS54: Patients' experience of an exacerbation of COPD. Lessons for primary health professionals

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Introduction: Patients are at the centre of managing their own disease but need the skills and support from health professionals to do so. An exacerbation is an unwelcome interruption to self management though is rarely sudden in onset. Helping to support self care in COPD is poorly developed in primary care and research has focused on the physical parameters of exacerbations using quantitative methods rather than the patient experience. **Aims:** The project aimed to gain insight into people with experience of an acute exacerbation of COPD. **Objectives:** For participants to recount their story of their most recent exacerbation which required admission to hospital. To identify implications for health professionals practice particularly in supporting self care strategies in patients living with COPD.

Subjects and method:

8 patients (5 men, 3 female) Age range 59–73